County of San Bernardino
Department of Behavioral Health

(Each physician responsible for this client's ongoing care must complete this form separately.)

INFORMATION RELEVANT TO CONSENT:
The undersigned physician for the client named below hereby certifies that he/she has supplied the following information regarding the administration of psychotropic medication to this client:

1. The nature of the client's medical condition;
2. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
3. The reasonable alternative treatments available, if any;
4. The type, range of frequency and amount (including the use of PRN orders), method (oral or injection), and duration of taking the medication;
5. The probable side effects of these drugs known to commonly occur, and particular side effects likely to occur with this particular client;
6. The possible additional side effects that may occur to clients taking such medication beyond three months: the client shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might, at times, include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after the medications have been discontinued;
7. Printed information on medications given to client: ☐ YES ☐ NO If answer is NO, WHY NOT?

_____

_____

_____ _____

DATE SIGNATURE OF PHYSICIAN

DATE AND M.D. INITIALS FOR EACH ADDITIONAL CLIENT CONSENT SIGNATURE BELOW _____

_____

CONSENT:
The client hereby acknowledges each time by signature below that:

1. I have participated to my satisfaction in the discussion and planning of my current medication services.
2. All the information above regarding the administration of psychotropic medications has been fully explained to me;
3. I understand this information and have no further questions at this time;
4. I understand that if I have questions after I have taken this medication, I will have an opportunity to discuss them with my physician;
5. I understand that nothing in this article prohibits a physician from taking appropriate action in an emergency;
6. I understand that I can withdraw this consent at any time by telling a member of the treating staff.

I DO CONSENT TO MY MEDICATION TREATMENT PLAN AND TO THE USE OF (list specific names of medications):

MEDICATIONS	DATE	SIGNATURE OF CLIENT

MEDICATIONS CONSENT FORM
County of San Bernardino
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information
See W&I Code 5328

NAME:

DOB:

CHART NO:

PROGRAM: